Order Code IB98037

Tax Benefits for Health Insurance: Current Legislation

Updated May 23, 2000

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Tax Benefits for Health Insurance: Current Legislation

SUMMARY

In the second session of the 106th Congress there is continuing interest in expanding tax benefits for health insurance. Both the House and Senate patient protection bills (H.R. 2990 and S. 1344, now in conference) include various provisions, as do House and Senate minimum wage bills (H.R. 3081 and the Senate amendment to H.R. 833, incorporating S. 625 dealing with bankruptcy reform). Proposals for a health insurance tax credit are receiving renewed attention. In addition, President Clinton has recommended changes in his FY2001 budget.

Current law contains significant tax benefits for health insurance. (1) Most important is the exclusion of employer-paid health insurance from the determination of income taxes. (Employer-paid health insurance is also excluded from employment taxes.) Nearly two-thirds of the noninstitutionalized population under age 65 is insured through employment-based insurance; on average, large employers pay about 80% of its cost, though some pay all and others none. The exclusion also applies to health insurance provided through cafeteria plans. (2) Self-employed taxpayers may deduct 60% of their health insurance payments, a proportion scheduled to rise to 100% in 2003. (3) Taxpayers who itemize deductions may deduct insurance payments to the extent they and other medical expenses exceed 7.5% of adjusted gross income. While not widely used, this deduction benefits some with employment-based insurance (for the employee share), some self-employed (the remaining 40% of their cost) and others who purchase individual market policies. (4) Coverage under Medicare and Medicaid is not considered taxable income. (5) With some exceptions, benefits actually received from either private or public insurance are not taxable.

By lowering the after-tax cost of insurance, the tax benefits help extend coverage to more people; they also lead insured people to obtain more coverage than otherwise. The incentives influence the way in which coverage is acquired: the uncapped exclusion for employer-paid insurance, which can benefit nearly all workers and is easy to administer, is partly responsible for the predominance of employment-based insurance in the United States. Employment-based insurance has both advantages and disadvantages for the typical worker.

The tax benefits also increase the demand for health care by enabling insured people to obtain services at discounted prices. This is one reason why prices for health care have risen more rapidly than the general rate of inflation. Moreover, since many people would likely obtain some insurance without the tax benefits, they can be an inefficient use of public dollars. They also raise questions of equity, largely because the tax savings they generate depend upon the taxpayer's marginal tax rate. When viewed as a form of personal consumption, giving tax incentives for health insurance provides more benefits to higher income families who may not need them. Comprehensive reforms (e.g., capping the employer exclusion or replacing it with deductions and credits) might address some of these concerns, though they could be difficult to implement and may cause serious inequities of their own.

MOST RECENT DEVELOPMENTS

The House and Senate patient protection bills (H.R. 2990 and S. 1344, now in conference) include provisions that would expand tax benefits for health insurance. Both would expand the availability of medical savings accounts and accelerate the full deduction of health insurance costs by self-employed taxpayers. The House bill would also authorize a new above-the-line deduction for health insurance for those without employer plans or whose employers pay less than 50% of the cost, while the Senate bill would allow carryovers and rollovers from cafeteria plans and flexible spending accounts. For details see the Legislation section below or CRS Report RL30144, Side-by-Side Comparison of H.R. 2990 and the Senate Amendment for Patient Protections, *coordinated by Jean Hearne and Hinda Chaikind.*

Tax benefits for health insurance are also included in the minimum wage legislation adopted by the House (H.R. 3081) and Senate (the Senate amendment to H.R. 833, incorporating S. 625 dealing with bankruptcy reform). Both would accelerate the full deduction for health insurance by the self employed; the Senate measure would also authorize a new above-the-line deduction for health insurance for those without employer plans or whose employers pay less than 50% of the cost.

President Clinton's FY2001 budget includes tax proposals for improving access to health insurance and making it more affordable: a 25% tax credit for individuals who buy into Medicare before age 65 (once that is authorized), a 25% tax credit for individuals who pay COBRA continuation coverage premiums, and a 20% credit to small businesses that begin offering health insurance.

BACKGROUND AND ANALYSIS

Tax Benefits in Current Law

Current law provides significant tax benefits for health insurance. The tax subsidies—for the most part federal income tax exclusions and deductions— are widely available, though not everyone can take advantage of them. They reward some people more than others, raising questions of equity. They influence the amount and type of coverage that people obtain, which affects their ability to choose doctors and other providers. In addition, the tax benefits affect the distribution and cost of health care.

Overview of Current Provisions

This section summarizes the current tax treatment of the principal ways that people of obtain health insurance. It describes general rules but does not discuss all limitations, qualifications, and exceptions. To understand possible effects on tax liability, readers may want to refer to the Appendix for an outline of the federal income tax formula. (For example, exclusions are items that are omitted from gross income, while deductions are subtracted from gross income in order to arrive at taxable income.) Section number references are to the Internal Revenue Code of 1986 as amended.

The tax treatment of long-term care insurance is not discussed below. For information on this topic, see CRS Report RL30254, *Long-Term Care: The President's FY2001 Budget Proposals and Related Legislation*, by Carol O'Shaughnessy, Bob Lyke, and Carolyn Merck.

Employment-Based Plans. Health insurance paid by employers generally is excluded from employees' gross income in determining their income tax liability; it also is not considered for either the employee's or the employer's share of employment taxes (i.e., social security, Medicare, and unemployment taxes). (Sections 106 and 3121, respectively) The income and employment tax exclusions apply to both single and family coverage, which includes the employee's spouse and dependents. Premiums paid by employees generally are not deductible aside from the exceptions noted below.

Nearly two-thirds of the noninstitutionalized population under age 65 is insured under an employment-based plan. On average, large employers pay about 80% of the cost for employment-based insurance, though some pay all and others pay none. Employers typically pay a smaller percentage for family than for single coverage.

Insurance benefits paid from employment-based plans are excluded from gross income if they are reimbursements for medical expenses or payments for permanent physical injuries. Benefits not meeting these tests are taxable in proportion to the share of the insurance costs paid by the employer that were excluded from gross income. (Sections 104 and 105) Benefits are also taxable to the extent taxpayers received a tax benefit from claiming a deduction for the expenses in a prior year (for example, if taxpayers claimed a medical expense deduction for expenditures in 1998 and then received an insurance reimbursement in 1999). In addition, benefits received by highly-compensated employees under discriminatory self-insured plans are partly taxable. A self-insured plan is one in which the employer assumes the risk for a health care plan and does not shift it to a third party.

Employers may deduct their insurance payments as a business expense. The deduction is not a tax benefit but a calculation necessary for the proper measurement of the net income that is subject to taxation.

The Joint Committee on Taxation (JCT) estimates the FY2000 federal revenue loss attributable to the exclusion for employer contributions for health insurance, medical care (including that provided through cafeteria plans and flexible spending accounts, described below) and long-term care insurance to be $58 billion. The estimate does not include the effect of the exclusion on employment taxes.

Medical Expense Deduction. Taxpayers who itemize their deductions may deduct unreimbursed medical expenses to the extent they exceed 7.5% of adjusted gross income (AGI). (Section 213) Medical expenses include health insurance premiums paid by the taxpayer, such as the employee's share of premiums in employment-based plans (described above), premiums for individual private market policies (described below), and part of the premiums paid by self-employed taxpayers (also described below). More generally, medical expenses include amounts paid for the "diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body." They also include certain transportation and lodging expenditures, qualified long-term care service costs, and long-term care premiums that do not exceed certain amounts. Currently, the deduction is intended to help only those with catastrophic expenses.

The medical expense deduction is not widely used. For most taxpayers, the standard deduction is larger than the sum of itemized deductions; moreover, most do not have unreimbursed expenses that exceed the 7.5% AGI floor. In 1996, about 27% of all individual income tax returns had itemized deductions, and of these only about 15% (i.e., about 4% of all returns) claimed a medical expense deduction.

The JCT estimates the FY2000 revenue loss attributable to the medical expense deduction (including long-term care expenses) to be $4.4 billion.

Individual Private Market Policies. Payments for private market health insurance purchased by individuals are a deductible medical expense, provided the taxpayer itemizes deductions and applies the 7.5% AGI floor as just described. Premiums for the following insurance, however, are not deductible: policies for loss of life, limb, sight, etc.; policies that pay guaranteed amounts each week for a stated number of weeks for hospitalization; and the part of car insurance that provides medical coverage for all persons injured in or by the policyholder's car. Benefits paid under accident and health insurance policies purchased by individuals are excluded from gross income, even if they exceed medical expenses.

About 6% of the noninstitutionalized population under age 65 is insured through these private policies. Likely purchasers include early retirees, young adults, employees without access to employment-based insurance, and the self-employed (see below).

Self-Employed Deduction. Self-employed taxpayers may deduct payments for health insurance in determining their AGI. (Section 162) Their insurance typically is an individual private market policy. The self-employed deduction, an "above-the-line" deduction, is not restricted to itemizers, as is the medical expense deduction. Following enactment of the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999 (P.L. 105-277), the deduction is 60% in 1999 through 2001, 70% in 2002, and 100% in 2003 and thereafter. So limited, the deduction cannot exceed the net profit and any other earned income from the business under which the plan is established, less deductions taken for certain retirement plans and for one-half the self-employment tax. It is not available for any month in which the taxpayer or the taxpayer's spouse is eligible to participate in a subsidized employment-based health plan (that is, one in which the employer pays part of the cost). These restrictions prevent taxpayers with little net income from their business (which may not be uncommon in a new business, for example, or in a part-time business that grows out of a hobby) from deducting much if any of their insurance payments. However, the portion not deductible under these rules may be treated as a deductible medical expense, subject to the limitations described above.

Self employed individuals include sole proprietors (single owners of unincorporated businesses), general partners, limited partners who receive guaranteed payments, and individuals who receive wages from S-corporations in which they are more than 2% shareholders. (S-corporation status may be elected by corporations that meet a number of Internal Revenue Code requirements. Among other things, they cannot have more than 75 shareholders or more than one class of stock. S-corporations are tax-reporting rather than tax-paying entities, in contrast to C-corporations that are subject to the corporate income tax.)

In 1995, about 3 million tax returns (about 2.5% of all returns) claimed the self-employed health insurance deduction. For FY2000, the JCT estimates the revenue loss attributable to the deduction (including the deduction for long-term care insurance) to be $1.2 billion.

Proposals to accelerate the deduction to 100% are discussed below.

Cafeteria Plans. Health benefits provided through a cafeteria plan are excludable for both income and employment tax purposes. A cafeteria plan is a written benefit plan under which employees may choose between receiving cash and certain nontaxable benefits such as health coverage or dependent care. (Cash here includes any taxable benefits.) Under an option known as a premium conversion plan, employees may elect to reduce their taxable wages in exchange for having their share of health insurance premiums paid on a pre-tax basis; the effect is the same as if employees could claim an above-the line deduction for their payments. President Clinton intends to establish a premium conversion plan for executive branch employees who participate in the Federal Employees Health Benefits Program (FEHBP). Legislative branch entities are also considering adopting this arrangement.

Nontaxable benefits provided through cafeteria plans are exempt from income and employment taxes under the Internal Revenue Code rules applicable to those benefits, such as employer-paid insurance (described above). A separate statutory provision (Section 125) extends these exclusions to situations in which employees are given the option of receiving cash; were it not for this provision, the nontaxable benefit would be taxable since the employees had been in constructive receipt of the cash.

In 1993, about 12% of the full-time employees of medium and large size private firms could participate in cafeteria plans. Actual participation would have been less. Proposals to allow a carryover of unused cafeteria plan benefits are discussed below.

Flexible Spending Accounts. Benefits paid from flexible spending accounts (FSAs) are also excludable for income and employment tax purposes. FSAs and cafeteria plans are closely related, but not all cafeteria plans have FSAs and not all FSAs are part of cafeteria plans. FSAs funded through salary reductions are exempt from taxation through cafeteria plan provisions (since otherwise employees would be in constructive receipt of cash) while FSAs funded by nonelective employer contributions are exempt directly under provisions applying to employer-paid insurance.

Health care FSAs must exhibit some of the risk-shifting and risk-distribution characteristics of insurance. Among other things, participants must elect a specific benefit amount prior to the start of a plan year; this election cannot be revoked except for changes in family status. The full benefit amount (less any benefits paid) must be made available throughout the entire year, even if employees spread their contributions throughout the year. Any amount unused at the end of the year must be forfeited to the employer (thus, “use it or lose it”). FSAs cannot be used to purchase insurance; however, they can be combined with premium conversion plans (described above) to achieve the same tax effect.

In 1993, about 36% of full-time employees in medium and large size private firms could have a health care FSA. Actual participation would have been less. Proposals to allow carryovers and rollovers of unused health care FSA balances are discussed below.

Medical Savings Accounts. Medical savings accounts (MSAs) are personal savings accounts for unreimbursed medical expenses. They are used to pay for health care not covered by insurance, including deductibles and copayments. Currently, a limited number of MSAs may be established by taxpayers who have qualifying high deductible insurance (and none other, with some exceptions) and who either are self-employed or work for a small employer.

Employer contributions to MSAs are excludable for both income and employment tax purposes, while individuals' contributions (allowed only if the employer does not contribute) are deductible for determining AGI. Contributions are limited to 65% of the insurance deductible for single coverage and 75% for family coverage. Account earnings are excludable as well, as are distributions used for unreimbursed medical expenses, with some exceptions. Non-qualified distributions are included in gross income and an additional 15% penalty is applied. For further information, see CRS Report 96-805, *The Health Insurance Portability and Accountability Act (HIPAA) of 1996: Guidance on Frequently Asked Questions*, by Beth C. Fuchs, Bob Lyke, Richard Price, and Madeleine Smith.

Tax-advantaged MSAs, which first could be established in 1997, are not yet widespread. The Internal Revenue Service (IRS) has determined that 42,477 MSA returns were filed for 1998 and that 44,784 are likely to be filed for 1999. For additional information, see General Accounting Office report HEHS-99-34, *Medical Savings Accounts: Results from Surveys of Insurers.* Proposals to expand eligibility for MSAs are discussed below.

MSAs should be distinguished from Medicare+Choice MSAs, which are discussed below.

Military and Veterans Health Care. Coverage under military and veterans health care programs is not taxable income, nor are the benefits these programs provide. The tax exclusion (Section 134) applies as well to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and Tricare, which serve military dependents, retirees, and retiree dependents. In 1996, about 2.2% of the noninstitutionalized population under age 65 had military or veterans health care as their primary form of coverage. The FY1999 revenue loss attributable to CHAMPUS and Tricare is $1.5 billion.

Medicare and Medicaid. Coverage under Medicare or Medicaid is not taxable income. Similarly, benefits paid from either program are not subject to taxation. Medicare covers over 38 million people, including 96% of those ages 65 and older. Medicaid covers over 41 million people. The JCT estimates the revenue loss attributable to the exclusion of Medicare benefits to be $24.9 billion in FY2000. Medicaid beneficiaries, who must meet certain categorical requirements (aged, blind, or disabled, or specified members of families with dependent children) are generally poor and unlikely to have tax liability.

The employment tax individuals pay for Medicare Part A is not a deductible medical expense. However, premiums paid by individuals who voluntarily enroll in Part A are deductible, provided the taxpayer itemizes deductions and applies the 7.5 % AGI floor as described above. (Medicare Part A is insurance for hospitalization, skilled nursing facilities, home health and hospice care. Individuals age 65 and older may voluntarily enroll in Part A if they or their spouse do not have at least 10 years of Medicare-covered employment.) Medicare Part B premiums are also deductible subject to those same limitations, as are

premiums for Medigap insurance. (Medicare Part B is supplementary insurance for doctors' fees and outpatient services. Medigap insurance is private insurance that covers Medicare deductibles, co-payments, and benefits not covered under Medicare.)

Beginning in 1999, legislation allows a limited number of Medicare beneficiaries to elect Medicare+Choice medical savings accounts instead of traditional Medicare. Contributions to these accounts (made only by the Secretary of Health and Human Services) are exempt from taxes, as are account earnings. Withdrawals are likewise not taxed nor subject to penalties if used to pay unreimbursed medical expenses, with some exceptions. Currently, no Medicare+Choice MSA plans are available for beneficiaries to join.

Some Consequences of the Tax Benefits

Increases in Coverage. By lowering the after-tax cost of insurance, the tax benefits described above help extend coverage to more people. This of course is the intention: Congress has long been concerned about whether people have access to health care. The public subsidy implicit in the incentives (foregone tax revenues) usually is justified on grounds that people would otherwise under-insure, that is, delay purchasing coverage in the hope that they will not become ill or have an accident. Uninsured people are an indication of market failure; they impose spill-over costs on society in the form of public health risks and uncompensated charity care (the free-rider problem). Moreover, if insurance were purchased only by people who most need health care, its cost would become prohibitive for others (the adverse selection problem).

But, the tax benefits also lead insured people to obtain more coverage than they would otherwise choose. They purchase insurance that covers more than hospitalization and other catastrophic expenses, such as routine doctor visits, prescription drugs, and dental care. They obtain coverage with smaller deductibles and copayments. Comprehensive coverage and lower cost-sharing are thought to lead to better preventive care and possibly long-run savings for certain medical conditions.

Source of Coverage. Tax benefits influence the way in which insurance coverage is acquired. The uncapped exclusion for employer-paid insurance, for example, which can benefit nearly all workers and is easy to administer, is partly responsible for the predominance of employment-based insurance in the United States. In contrast, restrictions on the deduction allowed for individual private market insurance may be one reason why that insurance covers only 6% of the population under age 65.

Employment-based insurance carries both advantages and disadvantages for the typical worker. Generally costs are lower, and usually individual premiums do not vary by age or risk. (Thus, young and healthy workers may pay more than their actuarial risk would cost, though they are protected as they get older or need additional health care.) However, plans chosen by employers may not meet individual workers' needs (particularly if there are limited options), and changing jobs may require both new insurance and doctors.

Increase in Health Care Use and Cost. The tax benefits increase the demand for health care by enabling insured people to obtain services at discounted prices. This induced demand can be beneficial to the extent it reflects needed health care (that which society deems everyone should have) that financial constraints otherwise would have prevented. It can be

wasteful to the extent it results in less essential or ineffective care. In either case, many economists argue, the additional demand is one reason why prices for health care have risen more rapidly than the general rate of inflation.

Whether insurance coverage could be encouraged without increasing the cost of health care has been a matter of debate. Comprehensive reforms that might accomplish this goal include capping the exclusion for employer-paid insurance and replacing both the exclusion and the deduction with a limited tax credit. But these changes could be difficult to implement and may create serious inequities. A 1994 Congressional Budget Office study, *The Tax Treatment of Employment-Based Health Insurance,* provides an overview of the issues and questions these approaches raise.

Many people probably would obtain some health insurance even without the tax benefits. The cost of subsidizing people for what they would otherwise do is an inefficient use of public dollars. Ideally, the tax incentives should lead to insurance being purchased only to the extent it results in better health care for society as a whole. But how they could be revised to accomplish this goal is a difficult question given the different ways insurance is provided, the various ways it is regulated, and the voluntary nature of decisions to purchase it.

Equity. Questions might be raised about the distribution of the tax incentives. Since as a practical matter they are not available to everyone, problems of horizontal equity arise. Workers without employment-based insurance generally cannot benefit from them, nor can many early retirees (people under the age of 65). Even if these individuals itemized their deductions, they can deduct health insurance premiums only to the extent that they (and other health care expenditures) exceed 7.5% of AGI. In contrast, the exclusion for employer-paid insurance is unlimited.

Even if everyone could benefit from the tax incentives, there would be questions of vertical equity. Tax savings from the exclusions and deductions described above generally are determined by taxpayers' marginal tax rate. Thus, taxpayers in the 15% tax bracket would save $600 from a $4,000 exclusion (i.e., $4,000 x 0.15), such as for an employer-paid premium, while taxpayers in the 36% bracket would save $1,440 (i.e., $4,000 x 0.36). If health insurance is considered a form of personal consumption (such as food or clothing), this pattern of benefits would strike many people as unfair. It is unlikely that a government grant program would be designed in this manner. However, to the extent that health insurance is considered a way of spreading catastrophic economic risk over multiple years, basing tax savings on marginal tax rates might be justified.

Current Proposals

In a typical Congress, well more than 100 bills are introduced regarding tax benefits for health insurance. This issue brief does not attempt to identify let alone discuss all of them; rather, its focus is on bills that have been (or are likely to be) reported from committee or considered on the House and Senate floor. For summaries of these measures, see the Legislation section, below. However, a number of representative measures are identified in the discussion that follows.

Congressional offices can construct comprehensive lists of bills on particular proposals by using the Legislative Information System (LIS) available through the CRS home page.

Under the Legislation heading, click on the LIS and then on Bill Text: Adv. In the Word/Phrase box, type either a term like "medical savings accounts" or a combination of words and connectors like "credit adj/5 health" or "deduction adj/5 health" and then click on Search. Depending on the terms and connectors used, search results may yield some irrelevant bills without identifying all relevant ones; thus, the lists should be reviewed carefully. For technical assistance with searches, offices might call the La Follette Congressional Reading Room at 7-7100.

Medical Savings Accounts

The Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191) authorized a limited number of tax-advantaged MSAs under a demonstration beginning in 1997. (See above for a summary of its provisions.) HIPAA limits MSA eligibility to individuals who either are self-employed or are covered by small employer plans (50 or fewer employees). It also restricts eligibility after the *earlier* of (1) December 31, 2000, or (2) specified dates in the years 1997-1999 following a determination that the number of taxpayers who have MSAs exceeds certain thresholds. Once eligibility is restricted under the latter tests, tax-advantaged MSAs generally will be limited to individuals who either were active participants (had contributions to their accounts) prior to the cut-off date or become active participants through a participating employer.

The thresholds were not exceeded in either 1997 or 1998, and the IRS projects that only 44,784 MSA returns will be filed in 1999, far lower than the 750,000 threshold. The slow growth of MSAs can be attributed to many factors, including consumer unfamiliarity and the reluctance of insurance agents to sell lower-priced policies, but the statutory restrictions undoubtedly are playing some role. Thus, proponents are urging Congress to expand eligibility for MSAs and modify restrictions on the required high deductible insurance. In their view, MSAs ought to be encouraged since they can make insurance more affordable, allow a wider choice among doctors, and protect patient rights better than government regulation. Critics generally oppose expansion, arguing that MSAs will result in adverse selection among health plans, underutilization of preventive care, and unwarranted tax breaks for high income families. (For early analysis of these and other questions, see CRS Report 96-409, *Medical Savings Accounts: Background Issues*, by Bob Lyke.) The Administration opposes expanding MSA eligibility.

The conference agreement on the omnibus tax bill (H.R. 2488, the Taxpayer Refund and Relief Act of 1999) that the President vetoed on September 23rd did not contain MSA provisions. An expansion of MSAs had been included in the original bill passed by the House on July 16th, but none was in the Senate amendment.

Both the House-passed and Senate-passed patient protection bills (H.R. 2990 and S. 1344) would expand the availability of MSAs. Among other things, both bills would:

- remove current law provisions restricting MSAs to employees of small employers and self-employed individuals, making them generally available to individuals with qualifying high deductible health plans;
- eliminate numerical limits on the number of taxpayers with MSAs;
- allow contributions up to the amount of the insurance deductible (thus deleting the 65% and 75% ceilings); and

- lower minimum insurance deductibles (prior to applying the cost-of-living adjustment) from $1,500 to $1,000 for single coverage and $3,000 to $2,000 for family coverage.

In addition, the House bill would allow MSAs to be offered under cafeteria plans and permit contributions to be made by both employers and employees. The Senate bill would allow rollovers to MSAs from cafeteria plans and flexible spending accounts, preempt state laws prohibiting health issues from offering high deductible plans, and modify the penalty for nonqualified distributions. The Senate bill would also authorize a high deductible insurance/MSA plan for the Federal Employees Health Benefits Program (FEHBP).

Other MSA bills include H.R. 55 (Representative Dreier), H.R. 448 (Representative Bilirakis), H.R. 614 (Representative Archer), H.R. 1136 (Representative Norwood), H.R. 1687 (Representative Shadegg), S. 300 (Senator Lott), S. 657 (Senator Inhofe), S. 1274 (Senator Grams), and S. 1350 (Senator Grassley).

Self-Employed Deduction

The Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999 (P.L. 105-277) accelerated the schedule for full deductibility of health insurance costs by the self-employed. Limited to 45% of the amount paid in 1998, the deduction will be 60% in 1999 through 2001, 70% in 2002, and 100% in 2003 and thereafter.

Several bills that have received legislative action would allow the full deduction sooner. H.R. 2990 (Representative Talent), the patient protection legislation that the House passed on October 6th, would allow a 100% deduction after December 31, 2000, even if taxpayers were eligible to participate (but did not) in an employer-subsidized plan. (Current law precludes those with such eligibility.) The Senate amendment (originally S. 1344) would allow the full deduction after 1999, though it would otherwise not change current law. Both the House and Senate minimum wage bills (H.R. 3081, incorporating H.R. 3832, and H.R. 833, formerly S. 625) would also accelerate full deductibility like the respective provisions in the patient protection legislation. Numerous other bills accelerating the date for full deductibility have been introduced as well.

The principal argument for increasing the deduction is equity. People who have employment-based insurance—nearly two-thirds of those under age 65—may exclude from their gross income the amount of insurance paid by the employer. The exclusion, which is uncapped, also applies to employment taxes. (In contrast, self-employed taxpayers may not deduct their health insurance expenditures in calculating their self-employment tax.) Equitable treatment between corporate owners and owners of unincorporated businesses would remove an incentive to choose the form of business organization merely for tax reasons. Since Congress has already decided to allow the full deduction, advancing the date it becomes available may raise only budget, not policy issues.

Nonetheless, questions might still be raised about whether a 100% deduction would be equitable. As mentioned above, large employers on average pay about 80% of the cost of the insurance they offer, leaving employees to pay the other 20% with after-tax dollars. Perhaps capping the deduction at 80% would be the equivalent, though this would not offset the employment tax exclusion. Moreover, self-employed taxpayers are owners; for the most part,

they can choose whatever insurance they want, even expensive coverage. A full deduction might not lead them to be as cost-conscious as corporate owners. Finally, it is debatable whether accelerating the deduction would make it more likely that the *employees* of self-employed owners will be provided health insurance. Some argue that the deduction should not be increased unless it is coupled with a nondiscrimination requirement. The original authorization for the deduction in 1986 had such a requirement, but it was repealed in 1989, leaving the owners with tax advantages their employees do not have.

Cafeteria Plans and Flexible Spending Accounts

The Patients' Bill of Rights Plus Act (S. 1344), which passed the Senate on July 15th (and which subsequently became the Senate amendment to H.R. 2990), would allow unused balances in cafeteria plans and flexible spending accounts (FSAs) to be carried over to the following year without being taxed. The annual limit would be $500. In the case of health care and dependent care FSAs, unused balances could also be distributed to participants (in which case they would be taxed) or rolled over into certain qualified deferred compensation plans (section 401(k), 403(b), and 457 plans) or a medical savings account (MSA). Other bills allowing carryovers and rollovers with respect to cafeteria plans and FSAs include H.R. 27 (Representative Dreier), H.R. 2350 (Representative Johnson of Texas), H.R. 2926 (Representative Boehner), S. 300 (Senator Lott), and S. 1274 (Senator Grams).

The principal argument for allowing these options is that taxpayers might be more willing to participate in cafeteria plans and FSAs if unused balances at the end of the year were not lost. Under current law, as explained above, unused balances must be forfeited. Allowing carryovers or rollovers might also discourage participants from spending remaining balances carelessly, just to use them up. Cafeteria plans and FSAs generally do not restrict patients' choice of doctors; thus, some might favor them as a way around limitations of managed care.

However, the options might result in tax breaks that are unwarranted, particularly for higher income families. Some participants might increase their FSA contributions just to take advantage of them. The health care FSA carryover could become another form of MSA, though limited in size and without account earnings that accrue to the employee.

A number of MSA bills include provisions that would allow them to be funded through cafeteria plans (e.g., H.R. 614, H.R. 1136, H.R. 1687, H.R. 2926, and H.R. 2990); this might increase the number of employers that offer cafeteria plans and the attractiveness of MSAs to employees.

President Clinton intends to implement a premium conversion plan for executive branch employees who participate in the Federal Employees Health Benefits Program (FEHBP). The plan would allow enrollees to pay their part of the premium on a pre-tax basis. The Administration claims that it can implement the plan without additional legislative authority.

Expanded Tax Deduction

H.R. 2990 (Representative Talent), the patient protection legislation that the House passed on October 6th, includes an above-the-line deduction (not limited to itemizers) for health insurance. The deduction would be limited during a phase-in period and would not apply to months in which taxpayer participates in a health plan maintained by employer if 50%

or more of cost is paid or incurred by employer, or if taxpayer is enrolled in certain public programs. The Senate amendment (originally S. 1344) does not include this provision. (For details, see the bill summaries below.)

The Senate minimum wage legislation (part of H.R. 833, formerly S. 625, dealing with bankruptcy reform) also includes a similar expanded tax deduction.

The Taxpayer Refund and Relief Act of 1999 (H.R. 2488), the omnibus tax bill that the President vetoed on September 23rd, would have allowed a similar above-the line deduction for health insurance. (Both the House and Senate versions of the legislation included a tax deduction provision.) It also would have allowed a new above-the-line deduction for prescription drug insurance coverage for Medicare beneficiaries (effective in 2003) if certain Medicare structural changes occur and low-income assistance is available.

Other bills allowing for an expanded deduction include H.R. 145 (Representative Green of Texas), H.R. 1177 (Representative Chabot), H.R. 2020 and H.R. 2261 (Representative Johnson of Connecticut), S. 194 (Senator Boxer), and S. 1274 (Senator Grams). Some of these bills would limit the deduction to individuals who are not eligible for employer-subsidized coverage.

Expanded tax deductions would improve horizontal equity since more taxpayers could receive tax benefits similar to those associated with employer-paid coverage. (An above-the-line deduction has the same income tax effect as the exclusion allowed that coverage.) As discussed above, the deduction allowed under current law is restricted to taxpayers who itemize and is further limited to insurance and medical costs that exceed 7.5% adjusted gross income; thus, most taxpayers cannot benefit from it.

At the same time, an expanded deduction would not improve vertical equity since the tax benefits generally would be proportional to the taxpayer's marginal tax rate. A $2,000 premium would result in tax savings of $720 for someone in the 36% bracket (i.e., $2,000 x 0.36) but only $300 for someone in the 15% bracket (i.e., $2,000 x 0.15). It might also be doubted whether tax savings of 15% would enable more lower income taxpayers to obtain insurance.

Tax Credit

There is growing interest in a tax credit for the purchase of health insurance. Recently a number of bills have been introduced that would authorize a generally available credit, among them H.R. 1136 (Representative Norwood), H.R. 1687 (Representative Shadegg) H.R. 1819 (Representative McDermott), H.R. 2020 and H.R. 2261 (Representative Johnson of Connecticut), H.R. 2185 (Representative Stark), H.R. 2362 and H.R. 4113 (Representative Armey), H.R. 2926 (Representative Boehner), S. 2320 (Senator Jeffords) and S. 2337 (Senator Santorum).

Several bills have also been introduced that would authorize tax credits for more limited purposes, such as helping military retirees and certain senior citizens pay Medicare Part B premiums (H.R. 121 and H.R. 122, introduced by Representative Emerson) or helping Medicare beneficiaries pay for supplemental prescription drug coverage (H.R. 4234, introduced by Representative Foley). The Democratic alternative to the Taxpayer Refund Act

of 1999 (S. 1429) as it was considered by the Senate Finance Committee included a 30% tax credit for individuals without employer-sponsored plans.

A tax credit could be attractive in several respects. If it were generally available, a credit could aid taxpayers who do not have access to employment-based insurance (or who are dissatisfied with it) and who cannot claim the medical expense deduction. A credit could provide all taxpayers with the same dollar reduction in final tax liability; this would avoid problems of vertical equity associated with the tax exclusion and tax deduction. A credit might also provide lower income taxpayers with greater tax savings than either the exclusion or the deduction; this might reduce the number of the uninsured. If the credit were refundable, it could even help taxpayers with limited or no tax liability.

But the effects of tax credits can vary widely, depending on how they are designed. One important question is whether the credit would supplement or replace existing tax benefits, particularly the exclusion for employer-paid insurance. Another is whether the credit would be the same for all taxpayers or more generous for those with lower incomes. (Ensuring that lower income families benefit from any credit may be difficult if they cannot afford to purchase insurance beforehand.) Similarly, it might be asked whether the credit would vary with factors that affect the cost of health insurance, such as age, gender, place of residence, or health status. Whether the insurance must meet certain standards for benefits, coinsurance, and underwriting might also be a factor.

President Clinton is proposing a 25% tax credit as part of his FY2001 budget. Eligibility would be limited to individuals who buy into Medicare before age 65 (once that is authorized) of who pay COBRA continuation coverage premiums.

Employer Tax Credit

The 1999 Senate tax bill (H.R. 2488, originally S. 1429) included a tax credit for small employers (9 or fewer employees, on average) for health insurance paid for certain lower income employees (individuals whose annual wages exceed $5,000 but not $16,000). The credit would equal 60% of the cost of individual coverage up to $1,000 and 70% of the cost of family coverage up to $1,715. This provision was not included in the conference agreement. President Clinton is proposing a 20% credit for small businesses that begin offering health insurance to their workers. Bills with an employer credit include H.R. 2574 (Representative Maloney).

Appendix

The Federal Income Tax Formula

Listed below is the general formula for calculating federal income taxes. The list omits some steps, such as prepayments (from withholding and estimated payments) and the alternative minimum tax.

1. Gross income
2. *minus* Deductions (or adjustments) for AGI (i.e., "above the line")
3. = Adjusted gross income (AGI)
4. *minus* Greater of standard or itemized deductions
5. *minus* Personal and dependency exemptions
6. = Taxable income
7. *times* Tax rate
8. = Tax on taxable income (regular tax liability)
9. *minus* Credits
10. = Final tax liability

LEGISLATION

The bills summarized below have been (or are likely to be) reported by committee or considered on the House or Senate floor. Congressional offices may obtain summaries of other bills and track their status by using the Legislative Information System (LIS) available through the CRS home page. Under the Legislation heading, click on "Bill Summary and Status for 106th Congress," search by bill number, and then click on either "CRS Summary" or "Bill Status." Some bills (particularly Senate bills) are also summarized in the *Congressional Record* when they are introduced. For guidance on searching for legislation addressing tax benefits for health insurance, see the introduction to Current Proposals, above.

H.R. 833 (Gekas)

The Senate amendment, the Bankruptcy Reform Act of 2000, incorporates the text of S. 625 as amended by the Senate. Among other things, the amendment allows self-employed taxpayers to deduct 100% of their health insurance costs starting in 2000 if they are not eligible to participate in an employer-subsidized health plan. Also allows an above-the-line deduction (not limited to itemizers)for health insurance premiums, limited to 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% in 2007 and thereafter. Does not apply to months in which individual participates in health plan sponsored by employer if 50% or more of cost is paid or incurred by employer, or if individual is enrolled in Medicare, Medicaid, FEHBP, the State Children's Health Insurance Program (SCHIP) or in certain armed forces, veterans, and Indian health service programs. S. 625 was introduced on March 16, 1999 by Senator Grassley; referred to Committee on Finance. Amended bill was incorporated into H.R. 833 on February 2, 2000.

H.R. 2488 (Archer)

The conference agreement on this omnibus tax bill, entitled the Taxpayer Refund and Relief Act of 1999, would have allowed (1) an above-the-line deduction for health insurance

(phased-in before 2007) except for months in which individual participates in health plan sponsored by employer if 50% or more of the cost is paid or incurred by employer, or if individual is enrolled in Medicare, Medicaid, FEHBP, the State Children's Health Insurance Program (SCHIP) or in certain armed forces, veterans, and Indian health service programs; (2) an above-the-line deduction for prescription drug insurance coverage for Medicare beneficiaries, subject to several contingencies; and (3) a deduction for 100% of insurance costs, starting in 2000, for self-employed taxpayers who do not participate in employer-subsidized plans. The conference agreement was passed by both the House and Senate on August 5th and vetoed by President Clinton on September 23, 1999.

H.R. 2488 was introduced on July 13, 1999, as the Financial Freedom Act of 1999 and referred to the Committee on Ways and Means. It was reported with amendments on July 16th and passed by the House with amendments on July 22nd. In addition to different versions of the three provisions included in the conference agreement, the House bill would also have extended and expanded eligibility for medical savings accounts. The Senate amendment, originally S. 1429 (described below), was passed by that body on July 30th.

H.R. 2990 (Talent)

Quality Care for the Uninsured Act of 1999. Among other things, provides above-the-line deduction (not limited to itemizers)for health insurance premiums, limited to 25% in 2002 through 2004, 35% in 2005, 65% in 2006, and 100% in 2007 and thereafter. Does not apply to months in which individual participates in health plan sponsored by employer if 50% or more of cost is paid or incurred by employer, or if individual is enrolled in Medicare, Medicaid, FEHBP, the State Children's Health Insurance Program (SCHIP)or in certain armed forces, veterans, and Indian health service programs. Allows self-employed taxpayers to deduct 100% of their insurance costs starting in 2001, provided they do not participate in employer-subsidized health plan. Also expands eligibility for MSAs (effective in 2001) by eliminating numerical limits on them, allowing individuals to have them regardless of employer or employment status, allowing them to be offered through cafeteria plans, increasing allowable contributions and permitting both employers and employees to contribute, and lowering the minimum insurance deductibles to $1,000 for single coverage and $2,000 for family coverage. Introduced September 30, 1999 and referred to Committee on Commerce and also Committees on Ways and Means and on Education and the Workforce. Passed House October 6th. Amended by Senate October 14th with language of S. 1344.

H.R. 3081 (Lazio)

Small Business Tax Fairness Act of 2000. This legislation, which is the House-passed minimum wage bill, includes a number of tax provisions; one allows self-employed taxpayers to deduct 100% of their health insurance costs starting in 2001, provided they do not participate in employer-subsidized health plan. Introduced on October 14, 1999, and referred to Committee on Ways and Means and the Committee on Education and the Workforce. Passed the House on March 9, 2000 with amendments, one of which incorporated the text of H.R. 3832.

S. 625 (Grassley)

See the summary for H.R. 833, above.

S. 1344 (Lott)

Patients' Bill of Rights Plus Act. Among other things, as passed by Senate the legislation expands eligibility for MSAs by eliminating numerical limits on them, allowing all employers to offer them, allowing all individuals generally to have them, increasing deduction for contributions, lowering minimum insurance deductibles (prior to applying the cost-of-living adjustment) to $1,000 for single coverage and $2,000 for family coverage, and eliminating penalty for non-qualified withdrawals that do not reduce account balance to less than annual insurance deductible. Authorizes MSAs and high deductible insurance under Federal Employees Health Benefits Program (FEHBP) and clarifies treatment of network-based managed care plans. In addition, allows full deduction of health insurance costs by self-employed taxpayers (effective in 2000) who are not eligible to participate in employer-subsidized plan; also allows carryovers and rollovers (to deferred compensation plans) with respect to cafeteria plans and FSAs. Introduced July 8th; placed on calendar. Passed Senate with amendments July 15th . On Oct. 14th, adopted as Senate amendment to H.R. 2990.

S. 1429 (Roth)

The Senate-passed version of this omnibus tax bill, entitled the Taxpayer Refund Act of 1999, was adopted on July 30, 1999, as the Senate amendment to H.R. 2488 (described above). In addition to the provision for self-employed taxpayers and a different version of the above-the line deduction for health insurance (both of which were included in the conference agreement on H.R. 2488), the Senate bill also would have authorized a new tax credit for small employers (9 or fewer employees, on average) for health insurance paid for employees whose annual wages exceed $5,000 but not $16,000, limited to 60% of the cost of individual coverage up to $1,000 and 70% of the cost of family coverage up to $1,715. S. 1429 was ordered reported as an original measure on July 21, 1999 by the Committee on Finance. It was reported on July 26th and passed the Senate with amendments on July 30th.

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